

## **MDR Tracking Number: M5-04-2838-01**

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on May 3, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

The IRO reviewed the office visits-99213, therapeutic exercises-97110, therapeutic procedures-97150, and physical performance testing (muscle testing)-97750-MT.

The office visits-99213, therapeutic exercises-97110, therapeutic procedures-97150, and physical performance testing (muscle testing)-97750-MT **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on the review of the disputed issues within the request, the Medical Review Division has determined that medical necessity was not the only issue to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On July 28, 2004 the Medical Review Division submitted a Notice to the requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 19 days of the requestor's receipt of the Notice.

The carrier denied CPT code 95851 on 05-13-03 and 05-16-03 with "G – unbundling (included in global)." The carrier did not specify which service this was global to. Therefore, CPT code 95851 will be reviewed according to the 96 MFG Schedule. Recommended reimbursement of  $\$36.00 \times 5 = \$180.00$ .

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 05-13-03 through 05-16-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 30<sup>th</sup> day of September 2004.

Patricia Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division

PR/pr

**MEDICAL REVIEW OF TEXAS**  
[IRO #5259]  
**3402 Vanshire Drive                      Austin, Texas 78738**  
**Phone: 512-402-1400                  FAX: 512-402-1012**

### **NOTICE OF INDEPENDENT REVIEW DETERMINATION**

TWCC Case Number:
MDR Tracking Number:    M5-04-2838-01
Name of Patient:
Name of URA/Payer:
Name of Provider: (ER, Hospital, or Other Facility)
Name of Physician: (Treating or Requesting)

June 24, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

Patient received examinations and physical medicine treatments after injuring herself while restraining a youth on \_\_\_\_.

REQUESTED SERVICE(S)

Office visits (99213) therapeutic exercises (97110), therapeutic procedures (97150), physical performance testing (muscle testing) (97750-MT from 05/23/03 through 06/27/03.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

The patient's pain ratings were recorded at the beginning (05/23/03) and at the end (06/27/03) of the care in question. The patient rated her pain at 1 on both of those dates thus indicating that no improvement took place.

More importantly, the examination performed on 03/26/03 and the examination performed on 05/13/03 revealed the following identical findings on both dates: restricted cervical ROM (with no degrees recorded), restricted lumbar ROM (with no degrees recorded), restricted right shoulder ROM (with no degrees recorded), positive cervical distraction and compression tests, positive sitting and standing Kemp's tests, positive straight leg raise at 80 degrees, positive Nachlas, Yeoman's and Ely's tests bilaterally and positive Patrick's test. Those pre and post treatment identical findings, in and of themselves, absolutely document that the previous treatment was ineffective and non-beneficial. Therefore, all care after 05/13/03 was medically unnecessary.